Health and Human Services Committee January 24, 2019

HOWARD: [00:00:00] Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Sara Howard. I represent District 9 in midtown Omaha and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: [00:00:15] Senator Dave Murman, District 38, south-central Nebraska.

ARCH: [00:00:19] Senator John Arch, Papillion-La Vista, District 14 .

WILLIAMS: [00:00:24] Matt Williams, Legislative District 36, Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH: [00:00:31] Machaela Cavanaugh, District 6, central-- west-central Omaha.

B. HANSEN: [00:00:36] Senator Ben Hansen, District 16, Washington, Burt, and Cuming Counties.

HOWARD: [00:00:42] Just in time. And Senator Walz will not be joining us. She's expecting a new grandbaby so she has gone down to Kansas City for the weekend. Also assisting our committee is our legal counsel Jennifer Carter and our committee clerk Sherry Shaffer. We have two wonderful pages with us, "Maddie" and Tsehaynesh. Did I get it?

TSEHAYNESH GHIDEY: [00:01:01] Yes.

HOWARD: [00:01:01] Fabulous. Oh, that's wonderful. Just a few notes about our policies and procedures. We ask that you turn off or silence your cell phones. And this afternoon we'll be hearing three bills and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room you'll find green testifier sheets. And if you're planning on testifying today, please fill one out and hand it to Sherry when you come up to testify. This will keep-- help us keep an accurate record of the hearing. If you're not testing on the mike-- testifying on the microphone but would like to go on record as having a position on the bill, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note if you're not testifying but would like to submit written testimony, the Legislature's policy is that all letters need to be received by the committee at 5:00 p.m. prior to the day of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have handouts, that you please bring ten copies and give them to the pages when you come to testify. We do use a light system in the Health and Human Services Committee. Each testifier has five minutes so you'll have a green light for four. It'll turn yellow for one minute. And then when it turns red, I'll start waving my arms and trying to assist you in concluding your testimony. When you do come up to testify, please state your name clearly and spell both your first and last name. The hearing will begin with the introducer's opening statement. We'll then hear from supporters, opponents, and neutral testifiers, and then the introducer will be given an opportunity to close. We do have a strict no-props policy in this committee. And with that, we will begin today's hearing with LB200. Welcome, Senator Wishart.

WISHART: [00:02:52] Thank you. Well, good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the great 27th District here in Lincoln. I am here today to introduce LB200, a bill that will ensure that essential drug and alcohol treatment programs are able to continue to perform their important mission. Since 1983, The Bridge Behavioral Health Center, which is located in District

27 in the Haymarket-- historic Haymarket, has provided civil protective custody services to Lincoln and Lancaster Counter-- County, offering a place where police officers can take people who have become a danger to themselves or others because of extreme intoxication due to alcohol or drugs. Last year the bridge received a letter from the Department of Health and Human Services indicating that licensure for The Bridge and other similar programs may be in jeopardy because of the use of locked rooms to secure individuals placed into civil protective custody. As I understand it, this issue arose from a new interpretation of old regulations. In response, 19 local elected and appointed officials sent a letter to Governor Pete Ricketts strongly supporting the CPC program as operated by The Bridge and expressing concern about the threat to program license-- licensure. I have provided the members of the committee with a copy of the letter to Governor Ricketts. Following me today will be experts who have been on the front lines of this issue who will provide in-depth testimony on the program, the issue, and how this legislation ensures that those needing the services of The Bridge Behavioral Health Center will continue to get the services that are needed. While ultimately there was a resolution that allowed for The Bridge to maintain its licensure temporarily, this legislation, if enacted, would ensure The Bridge and similar facilities keep their licensure moving forward. Following me will be Tammy Stevenson, executive director of The Bridge; Lincoln Police Chief Jeff Bliemeister; and Commissioner Sean Flowerday of the Lancaster County Board of Commissioners. I've also provided the committee a letter of support from ASUN. Thank you for your time and I'd be happy to answer any questions.

HOWARD: [00:05:12] Thank you. Are there questions for Senator Wishart? All right. Seeing none, are you staying to close?

WISHART: [00:05:19] Yeah, I'll stay to listen to the testimony.

HOWARD: [00:05:21] OK. Thank you. We'll now invite proponent testifiers. Good afternoon.

TAMMY STEVENSON: [00:05:40] Good afternoon. My name is Tammy Stevenson, T-a-m-m-y S-t-e-v-e-n-s-o-n. I'm the executive director of The Bridge Behavioral Health and I'm here today to voice my support for LB200. The Bridge Behavioral Health is a licensed, accredited substance-use treatment center serving Lincoln, Lancaster County, and southeast Nebraska. We provide detoxification and medical withdrawal services, substance use and mental health respite, and outpatient and residential treatment to those with limited financial resources. I'm here today to talk about a program that we have been licensed to operate for 35 years: civil protective custody. In 1979 the Nebraska Legislature passed legislation decriminalizing public intoxication. However, the need existed for a place where intoxicated individuals could stay if they were a danger to themselves or others. Since the early 1980s, The Bridge Behavioral Health has served as this safe and caring place. Our medically supervised program provides an alternative to jail when chronic addiction or episodic alcohol and/or drug use endangers lives. Staff provides intervention, medical treatment care coordination, and education. In 2018, the Department of Health and Human Services Licensure Unit reinterpreted regulations governing treatment centers that had not changed since 2004. In fact, Licensure conducted a site visit at The Bridge in 2011 and reported no findings in regards to how we operated the program. However, last year Licensure expressed concerns about our use of seclusion or placing individuals in a locked room while they were in protective custody. However, admissions to civil protective custody are involuntary and we are caring for individuals who are acutely intoxicated and whose behavior is often unpredictable and hostile. We accept individuals with BACs up to .5; that is over six times the legal limit. We also care for people who are under the influence of drugs. Specifically, a client using methamphetamine often demonstrates volatile, paranoid, and combative behavior. When law enforcement brings an individual to protective custody, staff process the admission and a nurse completes an assessment. The officer then places the individual in a secured room. If the client is medically stable and cooperative, we will release them to a responsible party. If there is no responsible party available, we continue to

care for this individual until they are no longer a danger to themselves or others. If The Bridge Behavioral Health were not allowed to secure clients in locked rooms at admission, we would not be able to provide the service that we do today. Law enforcement would instead take these individuals to jail. However, jail standards do not allow them to admit someone with a BAC higher than .25 until they've been medically cleared. That means law enforcement would be required to take these individuals to the emergency room for an evaluation before they could be admitted to jail. Out of the 3,600 individuals we served last year, nearly 40 percent had BACs higher than a .25. The impact on our hospitals and the jail would be staggering. We believe that serving these individuals in a substance-use treatment center is a much better option than jail. I have heard many testimonies over the years that reiterate the importance of this program from law enforcement, from university officials, from families, and from clients themselves who state they might not be alive if someone had not brought them to The Bridge. It is not unusual for my staff to wash clients' clothing, provide shoes and coats at the time of discharge, or refer clients to other agencies for additional services. My staff has a passion for this work and the continuum of care that we can offer is unmatched. If an individual chooses to stay voluntarily, it's a simple transfer back to the medical withdrawal unit where our clinicians and intervention nurses can continue to provide the necessary treatment. In the handouts that I've provided you there is program data, as well as a summary of actual admissions to protective custody, to give the committee just a small insight into the behaviors that my staff frequently observe. In conclusion, I respectfully ask the members of the committee to support this important legislation that would allow substance-use treatment centers such as The Bridge to provide civil protective custody services. Thank you.

HOWARD: [00:10:30] Thank you. Are there questions for Ms. Stevenson? Senator Arch.

ARCH: [00:10:35] I-- I have several, so.

TAMMY STEVENSON: [00:10:35] Yeah.

ARCH: [00:10:35] When you say you're medically directed, could--

TAMMY STEVENSON: [00:10:39] Yes.

ARCH: [00:10:40] -- could you explain that? The obvious question is, how are we monitoring the people in this, in this closed room, how do we know that they're safe, how do we know that medically they're doing OK as they--

TAMMY STEVENSON: [00:10:52] Right.

ARCH: [00:10:52] -- as, you know--

TAMMY STEVENSON: [00:10:55] Absolutely. My staff checks on clients every 30 minutes. We take vitals on these clients every four hours, certainly more often if necessary. Depending on what the situation is, we will often make strategic decisions in regards to what room we place them in, so they might be closer to the nurses' station. If there's been anybody that's demonstrated or talked about any kind of opportunities that might self-harm, we certainly increase the frequency of those checks. But we-- we are up and we are interacting with those individuals frequently. We're watching for consistent breathing and just monitoring and documenting that progress as we're watching them.

ARCH: [00:11:39] So-- so then who makes the decision to lock the door? Who makes the decision to confine them?

TAMMY STEVENSON: [00:11:45] Law enforcement., law enforcement admits them into the room.

ARCH: [00:11:48] Into the room.

TAMMY STEVENSON: [00:11:50] Yes.

ARCH: [00:11:51] Now do all, every client that comes, do they-- do they go into a locked room?

TAMMY STEVENSON: [00:11:56] Yes.

ARCH: [00:11:56] OK.

TAMMY STEVENSON: [00:11:57] Yes.

ARCH: [00:11:57] So there isn't a-- there isn't a physician making the-- the call at that point.

TAMMY STEVENSON: [00:12:02] No.

ARCH: [00:12:02] That's law enforcement that makes the call?

TAMMY STEVENSON: [00:12:04] That's correct.

ARCH: [00:12:04] You monitor them medically to make sure they-- they're stable and they're--

TAMMY STEVENSON: [00:12:08] Correct.

ARCH: [00:12:08] -- they're progressing well. Then who makes the decision to unlock the door?

TAMMY STEVENSON: [00:12:13] Our nurses have a discharge assessment and we-- it-- It's more extreme behaviors. It starts out are they volatile, are they combative, are they making threats to harm themselves. If they pass all of those checks, then we go down to a next series of things that says can they follow a simple command, are they oriented times three, are they able to toilet and care for themselves. And if they meet those requirements, then we will assess them for discharge. I should back up and say we begin to assess them for discharge when they dip below the legal limit. So once they dip below that .08, if you're 21 or older, that's when we start to assess them for discharge.

ARCH: [00:12:57] And is there a-- is there a step down from that or are they just discharged from the facility at that point?

TAMMY STEVENSON: [00:13:03] They're just discharged from the facility unless they choose to stay voluntarily.

ARCH: [00:13:06] And that-- then are they released from the protective custody at that point?

TAMMY STEVENSON: [00:13:12] Yes, yes.

HOWARD: [00:13:15] Other questions? Senator Cavanaugh.

CAVANAUGH: [00:13:18] Thank you for your testimony and for being here today.

TAMMY STEVENSON: [00:13:20] Yes.

CAVANAUGH: [00:13:21] Are there police on hand when-- when they're there? And at what point are the police no longer involved?

TAMMY STEVENSON: [00:13:28] At the time of admission the officer stays there while our recovery advocates complete the admission process. And then the nursing-- the nurse will do a nursing assessment assuming that the client is cooperative at that point. And then it's the officer who placed them in the room and shuts the door. And we do not have officers that are there 24 hours. Certainly if we have an incident, sometimes an individual will start in a-- what we call a regular room. And if they start to do some self-harming behaviors and we need to move them to one of what we call our quiet rooms, which is a single room--we also have two padded rooms--then we will call usually LPD back and then they will transfer the client to a different room for us. So they are just a phone call away if we have a scenario like that, but they're not there 24/7.

CAVANAUGH: [00:14:23] OK. Second question.

HOWARD: [00:14:24] Sure.

CAVANAUGH: [00:14:25] Does the client have a way to communicate to the nursing station?

TAMMY STEVENSON: [00:14:31] Oh, yes, absolutely, absolutely. And we're engaging with them during those checks unless they're of course sleeping or-- or things. But we're talking with them. The first--

CAVANAUGH: [00:14:41] Do they have like a nurse-- like in a hospital you would have a nurse-

call button?

TAMMY STEVENSON: [00:14:45] It's a much smaller unit than that.

CAVANAUGH: [00:14:46] OK.

TAMMY STEVENSON: [00:14:46] They-- they literally just have to stand up and come to the door and we've got tech staff that are out in the main floor and then the nurse in the nursing station right beside. Every room is within sight of our nurses' station, so that wouldn't be an issue. Yeah.

CAVANAUGH: [00:15:02] Thank you.

TAMMY STEVENSON: [00:15:04] You're welcome.

HOWARD: [00:15:05] Senator Hansen.

B. HANSEN: [00:15:05] Just a couple questions.

TAMMY STEVENSON: [00:15:08] Yes.

B. HANSEN: [00:15:09] Do you see any litigious problems with, you know, being able to lock somebody in a room, from you guys' standpoint, like any-- where any-- anything where anybody getting sued by anyone? I don't-- I don't really know for sure. I'm just kind of curious if you guys have--

TAMMY STEVENSON: [00:15:21] No.

B. HANSEN: [00:15:22] OK. OK.

TAMMY STEVENSON: [00:15:23] No.

B. HANSEN: [00:15:23] Just-- I was just wondering, so-- I couldn't think of any either, so.

TAMMY STEVENSON: [00:15:25] Yeah. Yeah.

B. HANSEN: [00:15:27] And do these rooms that you put them in, do they have cameras in them at all-- at all?

TAMMY STEVENSON: [00:15:30] They do not. We do not have cameras in them. The restroom areas, there is a half-wall to provide some privacy, but we are able to see the extent of the room when we're at--

B. HANSEN: [00:15:42] OK.

TAMMY STEVENSON: [00:15:42] They have large windows up front that we can close, you know, or block off for some privacy. But we absolutely have full visibility of the rooms.

B. HANSEN: [00:15:50] Cool. Excellent. OK. So you know when they might be hurting themselves in there, who knows what, you know.

TAMMY STEVENSON: [00:15:53] Absolutely. Absolutely.

B. HANSEN: [00:15:54] And how long-- you might have said in here, but I thought it might have been 24 hours, but how long can you legally keep them in a locked room?

TAMMY STEVENSON: [00:16:01] The-- by statute it can be no longer than 24 hours.

B. HANSEN: [00:16:06] OK.

TAMMY STEVENSON: [00:16:06] But really it-- it's rarely that long because we start to assess them for discharge once they dip below the legal level--

B. HANSEN: [00:16:13] Sure.

TAMMY STEVENSON: [00:16:13] -- legal limit. So I think right now the latest report I ran, the average stay is between seven and eight hours. Our first step is always to see if we can find a responsible family member or a friend that can care for them.

B. HANSEN: [00:16:28] Sure. Right.

TAMMY STEVENSON: [00:16:28] So the first thing that we're doing upon admit is getting names and phone numbers and then we make those phone calls and see if we can find somebody that can care for them. And then we provide instructions for how they can care for them. Clearly for somebody who's combative and volatile, we're not going to release them to a responsible, you know, party. Or sometimes some of our clients don't have somebody to call. So then those are the ones that-- that we stay a little bit longer.

B. HANSEN: [00:16:50] All right. Great. Thank you.

TAMMY STEVENSON: [00:16:52] You're welcome.

HOWARD: [00:16:52] Other questions? Senator Williams.

WILLIAMS: [00:16:56] Thank you, Chairwoman Howard. Thank you for being with us. Quickly, so you've been operating since 2004 under the current regulations--

TAMMY STEVENSON: [00:17:06] Correct.

WILLIAMS: [00:17:07] -- and no significant problems during that period of time.

TAMMY STEVENSON: [00:17:10] No. With licensure--

WILLIAMS: [00:17:11] And now through the reinterpretation of those rules is why we're here to fix it.

TAMMY STEVENSON: [00:17:15] Yes.

WILLIAMS: [00:17:15] What other units around the state are there that do what you do?

TAMMY STEVENSON: [00:17:20] In Omaha, the Douglas County Mental Health Center operates the civil protective custody services. To my knowledge, there is not another substance-use treatment center that provides this service in Nebraska. It is certainly happening in smaller communities. It's just happening in hospitals and in the jails, but they don't have-- the communities aren't large enough that would have its own substance-use treatment center providing that service.

But--

WILLIAMS: [00:17:48] And the unit in Douglas County, are they set up and handle people the same way that you do?

TAMMY STEVENSON: [00:17:54] Yes.

WILLIAMS: [00:17:55] OK. Thank you.

TAMMY STEVENSON: [00:17:55] Yes.

HOWARD: [00:17:57] Any other questions? Seeing none, thank you for your testimony today.

TAMMY STEVENSON: [00:18:02] Yes. Thank you.

HOWARD: [00:18:02] Our next proponent. Good afternoon.

JEFF BLIEMEISTER: [00:18:21] Good afternoon, Senators. My name is Jeff Bliemeister, J-e-f-f-B-l-i-e-m-e-i-s-t-e-r. And I have the opportunity to serve the city of Lincoln as the police chief and I've served in that capacity since April of 2016. Prior to that, I served the Lancaster County Sheriff's Office for more than 20 years. And I want to thank you for the opportunity to support and advocate for LB200. And there were some great, very, very good questions on all accounts. Those are questions that I would ask myself. And I'd ask that the letter that's being distributed right now and the corresponding statistics be part of the record. So for the Lincoln Police Department, civil protective custody truly prevents victimization, it prevents crimes from being committed by those heavily influenced by alcohol and illicit drugs, it reduces bookings into the Lancaster County Jail,

and it minimizes stress on the emergency rooms, in particular Brian Health Systems based on the proximity to the downtown location. The services at The Bridge that begin with a CPS provide an opportunity to change the course of a life, and I've personally experienced that throughout my tenure in law enforcement. This continuum of care is outside the scope of the Lincoln Police officers that are bringing individuals to The Bridge; it's outside the scope of incarceration through the jail and through the emergency rooms. I can attribute that the policies and the practices and the leadership at The Bridge, which you just heard from Tammy Stevenson, are designed to provide protection to those with enhanced vulnerability because they are heavily under the influence of alcohol and drugs, so much so that they're unable to care for themselves, which is why they're being brought to the facility in the first place. This does include utilizing locked rooms. Some of the statistics that I passed out really govern over the last ten years, so 75 assaults, 75 assaults that are broken down between Tammy's staff, Lincoln Police officers, and other clients. It has to be taken within the context of how many people have been served. Literally over 30,000 people have been served at The Bridge during that time period. While one assault is one too many, without the policies and practices, including locked rooms, in place, I have absolutely no doubt that those particular numbers would be exponentially higher. The Bridge and law enforcement have had a decades-long partnership. It has enhanced the safety of our community, I have absolutely no doubt. The Lincoln Police Department has and will continue to support The Bridge both with our resources and with our finances. And I truly believe that the passage of LB200 will be a step towards sustainability of this longstanding program. And with that, I invite any questions that you may have.

HOWARD: [00:21:26] All right.. Are there any questions for the committee-- from the committee? Senator Arch.

ARCH: [00:21:31] What's the legal disposition of these clients?

JEFF BLIEMEISTER: [00:21:35] That's a great question. So Tammy talked about the decriminalizing of public intoxication, which in my opinion is good. But the CPC statutes allow us to take someone who is a danger to themselves or others based upon their level of intoxication into protective custody for 24 hours. And how that manifests itself is through The Bridge. So I'll take you through just a couple very scenario-- or scenarios that happen every day. One is last year we arrested approximately 1,000 drunk drivers. The majority of those drunk drivers that don't rise to the level of a felony offense are transported to The Bridge because we have a partnership there where we're doing the rest of the testing, the alcohol testing, in a portion of that facility. Following that testing, the individuals are brought upstairs by our officers. They're evaluated by Tammy's staff and then they're placed into protective custody. But just like Tammy said that the vast majority of those individuals while under the influence of alcohol or drugs that led them there, they're cooperative. And either our officers have already begun the process when they're driving them down there and calling a loved one who's of age and is sober and willing to take responsibility for them, so that process has already begun and the options are still provided by Tammy and her staff, but they're-- the amount of time that they spend behind any kind of locked door is very minimal. And here's another-- so that one's associated with a criminal citation, right? We could still be bringing all of those thousands of-- that 1,000 individuals to jail, which we're glad that we don't have to and I can attest that Lancaster County Corrections is glad that we don't. But Friday, Saturday nights, downtown Lincoln, especially when it's game day, is-- it's a unique experience. I would anticipate some of you have experienced that before, maybe not recently, but I would invite you to come down and do that. And there are individuals that have overconsumed and they're making choices that they wouldn't make otherwise. And that's placing themselves in jeopardy, whether they're darting across "O" Street and getting struck by a car, whether they're exposing themselves to some type of victimization or they're making bad decisions and assaulting someone else, all of those individuals are interacting-- so we have a heavy contingent of officers in that location and that's where they're-- they're observing these behaviors, they're trying to intercede

before there is any kind of criminal action. And a component of that prevention is the ability to take them to The Bridge to have the nursing staff care for them and it's efficient. Then the officers can get back to what they're more skilled at, and that's the prevention of crimes downtown. So statutorily it allows us to do this, and practically it does prevent crime from occurring. Hopefully that answers your question, Senator.

HOWARD: [00:24:47] Other questions? Seeing none, thank you for your testimony today.

JEFF BLIEMEISTER: [00:24:55] Thank you.

HOWARD: [00:24:55] Our next proponent. Good afternoon.

SEAN FLOWERDAY: [00:25:08] Hi there. Good afternoon, Chairwoman Howard and the members of the Health and Human Services Committee. My name is Sean Flowerday. Sean is spelled the right way: S-e-a-n. And Flowerday is spelled like it sounds: F-l-o-w-e-r-d-a-y. I am a member of the Lancaster County Board of Commissioners. I represent District 1. And I'm here to testify on behalf of the Lancaster County Board in favor of LB200. And Senator Wishart providing you with the letter that was sent to Governor Ricketts in June of 2018, you've also heard testimony from Bridge executive Tammy Stevenson and Lincoln Police Chief Jeffrey Bliemeister. I'd like to add the following points for your consideration. The Bridge civil protective custody program has operated effectively since 1983 and has the full support of Lancaster County, the city of Lincoln, the University of Nebraska, and law enforcement agencies throughout southeast Nebraska. The program plays a key role in our community's approach to the management of crises created by alcohol and drug addiction. The program also plays an important role in how our community handles emerge-- emergency protective custody for individuals who become a danger to themselves or others from mental illness. At times there's a very fine line between civil productive custody and

emergency protective custody and in some cases The Bridge offers a lower cost and less restrictive alternative for the care of individuals suffering from the combined effects of mental illness and severe intoxication. By definition, a person placed in-- into civil protective custody is intoxicated to the point where they are-- are a danger to themselves or others. Under these circumstances the initial use of room confinement provides the best protection for the individual, staff, and other residents in the facility. This model has been used successfully since 1983. This isn't a new thing. For the above reasons and based on the testimony of Tammy Stevenson and Chief Bliemeister, the Lancaster County board LB200. I'd be happy to answer any questions. Well, the final point that I would just make on behalf of the county board is this is going to put-- the new interpretation puts an undue stress on our county jail system, on the hospitals in our community, and we already have a lower cost, less restrictive option that has worked well for nearly four decades.

HOWARD: [00:27:21] Thank you. Commissioner.

SEAN FLOWERDAY: [00:27:23] Thanks.

HOWARD: [00:27:23] Any questions? Senator Williams.

WILLIAMS: [00:27:26] Thank you, Chairman Howard. Thank you, Sean, for being here today. Does the county participate in the funding for The Bridge?

SEAN FLOWERDAY: [00:27:34] Yes, it does.

WILLIAMS: [00:27:34] Do you know what the other funding sources are?

SEAN FLOWERDAY: [00:27:37] I--

WILLIAMS: [00:27:37] I should have asked Tammy that but didn't.

SEAN FLOWERDAY: [00:27:38] I-- I know the city of Lincoln is-- is part of it. I couldn't tell you everything. I know-- I know some of the funding comes from the-- the joint budget committee.

WILLIAMS: [00:27:47] OK.

SEAN FLOWERDAY: [00:27:47] Yeah.

HOWARD: [00:27:48] Other questions?

SEAN FLOWERDAY: [00:27:48] Thanks much.

HOWARD: [00:27:51] Seeing none, thank you. Nice to see you.

SEAN FLOWERDAY: [00:27:53] Yep, nice to see you too.

HOWARD: [00:27:56] Other proponents? Seeing none, we do have one letter to read into the record for proponents. It's from Larry Dix from the Nebraska Association of County Officials. We'll now open the floor for any opponent testifiers. Seeing none, is there anyone wishing to testify in a neutral capacity?

DARRELL KLEIN: [00:28:28] Good afternoon, Chair-- Chairwoman Howard and members of the Health and Human Services Committee. My name is Darrell Klein. Darrell is D-a-r-r-e-l-l, and I'm not sure that's the right way to spell it or not, but-- [LAUGHTER] and my last name, Klein, K-l-

e-i-n, and also capable of multiple spellings. I am a deputy director for the Division of Public Health in the-- in the Department of Health and Human Services. And I'm here to testify in a neutral capacity to LB200. The Licensure Unit in the Division of Public Health has standard practices and procedures for issuing a new license or for renewing a license for a mental health/substance-use treatment center. The team considers a variety of factors when determining a facility's compliance with the state regulations. And some considerations include but are not limited to a review of the policies, procedures, and standing physician protocols of the facility regarding a secured environment and the use of restraint and seclusion. We also review staff training specific to the use of restraint and seclusion and a review of client records relating to the use of restraint and seclusion; also, observations and interviews related to secured environments and the use of restraint and seclusion. A facility that employs restraint and/or seclusion can be licensed if the facility meets the overall standard for licensure. Another factor at play is accreditation, which impacts other divisions' ability to fund services. A license issued by the Division of Public Health allows a facility to operate. For the Divisions of Behavioral Health and Medicaid and Long-Term Care, accreditation by an outside entity signals for them that treatment is being provided. And the accrediting bodies for this facility type are the Commission on Accreditation of Rehabilitation Facilities, or "CARF," the Joint Commission on Accreditation of Healthcare Organizations, or "JCAHO," and the Council on Accreditation for Children and Family Services, or "COA." A facility can be licensed whether or not it chooses to become accredited, and the Divisions of Behavioral Health and Medicaid and Long-Term Care fund behavioral health treatment services including substance-use disorder treatment for individuals who are financially and clinically eligible and in need of such treatment. Social detoxification treatment services are included in the Behavioral Health and Medicaid continuum of care. Both divisions will reimburse for covered services including social detoxification regardless of whether the services are delivered voluntarily or involuntarily. Most importantly, accreditation is needed for these divisions to fund these services. Facilities that serve as a drop-off center for persons taken into civil protective custody, or CPC, and offer services

delivered to individuals under CPC do not meet service definitions of social detoxification or any other behavioral health and Medicaid-covered service. Thus, those services which are not accredited are not eligible for reimbursement because it is confinement and not treatment. And finally, on behalf of the department, I'd like to offer a technical change for the committee's consideration if you decide to advance this bill out of committee. The terminology used in-- in the current Nebraska Revised Statute 53-1,121 and the proposed new language references alcoholism center, which is not consistent with statutory changes that went into effect in July of 2018 as part of LB1034. And the correct facility type is mental health substance use treatment center. And updating the terminology to keep the language consistent with existing law leaves no doubt regarding the type of facility the new language in LB200 speaks to. And I-- thank you for your time this afternoon and I will do my best to answer your questions.

HOWARD: [00:32:41] Thank you, Mr. Klein. Are there questions?

ARCH: [00:32:45] Yes.

HOWARD: [00:32:46] Senator Arch.

ARCH: [00:32:48] So is-- is this then a mental health substance abuse treatment center?

DARRELL KLEIN: [00:32:53] That is the-- I believe so, yes.

ARCH: [00:32:56] OK.

DARRELL KLEIN: [00:32:57] The--

ARCH: [00:32:57] So what's confusing of course is that-- well, you probably know what's confusing. A lot of things are confusing in behavioral health. But-- but the-- but the designation of this as confinement not treatment but the-- but the-- the facility is called the treatment center.

DARRELL KLEIN: [00:33:13] Yeah. There is-- I think that the language in the testimony is-- is a reflection of the accreditation bodies' considerations with that. And we're just pointing out that there is a-- there's-- there are issues beyond licensure. The bill does address licensure and we understand that and so that was I think the point there. And as far as the facility name, what we had in the past were mental health centers and substance abuse treatment centers. And each of those sets of regulations, which of course are under revision and will be merged for the new facility type, did allow for unaccredited facilities to use seclusion under specified circumstances, which is reflected in the earlier testimony, what we look at in terms of the-- essentially the safeguards in place. Another way you can become licensed through [INAUDIBLE] status is if you're accredited, but you don't have to be accredited to have a license. So the distinction there between what is regarded as treatment and what is regarded as confinement I think is a reflection of what the accrediting bodies' positions is.

ARCH: [00:34:31] Thank you.

HOWARD: [00:34:31] Other questions? Senator Hansen.

B. HANSEN: [00:34:34] So if somebody has Medicaid and they end up getting sent to like a jail for detox as opposed to this facility, they-- one gets covered and one doesn't?

DARRELL KLEIN: [00:34:44] I'm going to-- through lack of actual expertise, I will defer Medicaid and behavioral health questions and we'll get back to you--

B. HANSEN: [00:34:56] OK.

DARRELL KLEIN: [00:34:56] -- on that because I don't want to accidentally misstate something.

B. HANSEN: [00:34:58] That's fine. I'm just curious to make sure that we're--

DARRELL KLEIN: [00:35:00] I would--

B. HANSEN: [00:35:00] -- looking out for the taxpayer money, you know.

DARRELL KLEIN: [00:35:01] I think you understand-- I understand from the nature of your question. I think I know what the answer is, too, but I wanted to-- you're asking if they are sent to-- to jail and it's confinement. They wouldn't be eligible for reimbursement.

B. HANSEN: [00:35:15] Yeah, or they would or would not [INAUDIBLE] --

DARRELL KLEIN: [00:35:18] Yeah.

B. HANSEN: [00:35:19] -- clarifying it just a little bit [INAUDIBLE].

DARRELL KLEIN: [00:35:19] Yeah. I think it-- I think if they-- it would depend on the accreditation, my understanding, and I would assume that-- maybe that jail is not. But I don't know that for a fact.

B. HANSEN: [00:35:28] Just curious. Thank you. .

HOWARD: [00:35:30] There may be some follow-up, but my understanding is when you're in a correctional facility you cannot bill Medicaid. You have to have a medical license or be accredited--

DARRELL KLEIN: [00:35:41] Yeah.

HOWARD: [00:35:41] -- and have a facilities licensure in order to bill any Medicaid program.

DARRELL KLEIN: [00:35:45] Yeah.

B. HANSEN: [00:35:47] [INAUDIBLE]

HOWARD: [00:35:49] And, Mr. Klein, can you tell me, what precipitated the-- the change in policy that brought this issue to us?

DARRELL KLEIN: [00:35:57] You know, I-- I was not working with the program in this area so I can't speak to the past. I will say that it's my read of the-- of the existing regulations, which have now been kind of superseded, that the review of the very elements that we talked about in our testimony in terms of the protocols and essentially safeguards in place. I-- I think those were already in the regulations and the regulations didn't change. And I am unaware of what precipitating circumstances might-- might have or might not have led to a-- a reinterpretation of it. I-- I plead ignorance.

HOWARD: [00:36:34] OK. Thank you, Mr. Klein.

DARRELL KLEIN: [00:36:35] Yeah.

HOWARD: [00:36:35] Senator Murman. Yeah, thanks for coming. Is there a charge for people that stay in this facility? You know, nothing that public health administers. And I am-- I am unaware of what the facility's policies are.

MURMAN: [00:36:54] OK. Just curious. Thanks.

DARRELL KLEIN: [00:36:56] Yeah. I think for-- for facilities that are eligible for reimbursement because they're accredited, that that would imply that there is a charge for the services, so, but I don't know about CPC.

HOWARD: [00:37:11] Any other questions? Seeing none, thank you for your testimony.

DARRELL KLEIN: [00:37:15] Thank you very much.

HOWARD: [00:37:17] Is there anyone wishing to testify in a neutral capacity? All right. Seeing none, Senator Wishart. Senator Wishart waives closing and this will close the hearing for LB200 and we will move on to open the hearing for LB60, Senator Cavanaugh, "Change terminology relating to shaken baby syndrome." Welcome, Senator Cavanaugh.

CAVANAUGH: [00:38:26] Thank you, Chairwoman Howard and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, and "Machaela" is definitely not spelled the traditional way, so, but probably the right way, just not traditional. I represent District 6 in west-central Omaha and I'm here to introduce LB60 today in order to update obsolete terminology that exists within current state statute, in statute regarding abusive head trauma in infants. This bill was prompted by both the LR419 from last year and

conversations with healthcare professionals. While the term "shaken baby syndrome" is well-known and widely used, it does not fully describe the scope of potential causes of abusive head trauma and is inconsistent with modern medical terminology. While many children who suffer from abusive head trauma were subjected to shaking as an infant, it also-- it can also be caused by blunt impacts to the infant's head, or a combination of the two. Ensuring that causes are properly described by the mandated educational materials given to new parents will play an important role in preventing efforts-- and I would like to just maybe strike that?

HOWARD: [00:39:48] It's fine.

CAVANAUGH: [00:39:48] OK. Additionally, the bill includes information about crying plans in those same materials as another measure to help prevent sudden infant death syndrome and abusive head trauma. Finally, you should all have a copy of AM17 which incorporates language suggested by the Department of Health and Human Services. The amendment changes language relating to prevention of sudden infant death syndrome to be more accurate than current state-- current statute. In closing, I ask that you approve AM17 and advance LB60. Thank you.

HOWARD: [00:40:23] Thank you. Any questions? Seeing none, you'll be staying to close?

CAVANAUGH: [00:40:29] Yes.

HOWARD: [00:40:31] Fabulous. All right. We'll now open up the testimony to any proponents for LB60.

JEFF STEC: [00:40:45] Hello.

HOWARD: [00:40:50] Good afternoon.

JEFF STEC: [00:40:50] Good afternoon. Senator Howard and members of the committee. My name is Jeff Stec, J-e-f-f, last name is S-t-e-c. Today I'm testifying in support of LB60 on behalf of Madonna Rehabilitation Hospitals. As background, I'm the pediatric program manager at Madonna and chair of the International Pediatric Collaborative, which is a consortium of over 50 providers of pediatric rehabilitation services in the United States, and it includes members from Canada and the Middle East. Additionally, I serve as the program surveyor for the Commission on Accreditation of Rehabilitation Facilities International where I provide on-site review of demonstrated conformance to international standards of care, organizations competing for CARF accreditation in the pediatric rehabilitation arena. I've practiced speech-language pathology since graduating with my master's of science degree from Kearney, Nebraska, in 1995, and completing postgraduate work with early intervention and feeding and swallowing at the University of Cincinnati in 2006. I appreciate Senator Cavanaugh bringing LB60 forward to update existing statute by replacing "shaken baby syndrome" terminology with "abusive head trauma," which is a more inclusive and current term. Additionally, I support the use of crying plans in the educational materials provided to caregivers. According to recent publications, in the first year of life, the incidence of abusive head trauma in the United States is estimated to be approximately 35 cases per 100,000 live births. The morbidity and mortality from abusive head trauma are significant. Approximately 65 percent have significant neurological disabilities and 5 to 35 percent of infants-- of injuries sustained are fatal. Most survivors have cognitive and neurologic impairment that will persist throughout a child's lifetime. The label "shaken baby syndrome" highlights the mechanism of injury, shaking. In contrast, abusive head trauma is more comprehensive and inclusive because abuse includes additional actions that may include blunt impact and is, therefore, more appropriate. So I may be frustrated and shaking my child. That's one way to injure my child,. But it could also happen if I threw them or if they were thrown down the stairs, hit, kicked, etcetera. That would also create this type of a head trauma.

In April 2012 the CDC issued recommendation definitions for public health surveillance and research for pediatric abusive head trauma. As of May 2018, the Journal of Pediatric Radiology published a consensus statement building on 15 national and international medical societies and organizations confirming the appropriate use of "abusive head trauma" as the most inclusive term and aligning with current language in LB60 replacing "shaken baby syndrome." The National Center on Shaken Baby Syndrome identifies crying as the number-one trigger of abuse in children less than six months of age. Facilitating the education about concrete strategies such as a crying plan for those who care for very young children prevents death and disability. The continuation for those training requirements for children-- childcare providers, parents, public as described in LB60 will have a significant impact. The children impacted by abusive head trauma require support for a lifetime. Our ability to prevent that from happening through exceptional educational programming helps caregivers anticipate the challenging and persistent crying of a new addition to the family or day-care community. When families or care communities are able to use those strategies in advance of a crying episode, the risks to children are lowered and fatal injury or a lifetime of recovery are reduced. Brain injury at any age is life changing. The abuse of an infant by a family member or care provider complicates the family system in a way that further impacts success for all of the members of the family. Taking steps to prevent that from happening preemptively impacts the quality of life, safety, and overall security when implemented effectively. Thank you for your ongoing efforts in the prevention, care, and support of children who have sustained abusive trauma specifically identified in this bill, and I am happy to take any questions.

HOWARD: [00:45:40] Thank you. Are there questions? Senator Murman.

MURMAN: [00:45:48] Thanks for coming in, Jeff. I do agree that this new term is more inclusive. I'm just wondering if the shaken baby syndrome would be more descriptive. I think you-- you said that most of the injuries are caused by shaking.

JEFF STEC: [00:46:10] A number of them are. It's actually more inclusive to have the "abuse" label as part of the term. They are used somewhat interchangeably. But from a research standpoint and from the nomenclature in the literature, it makes more sense for us to I think go to that "abusive head trauma" approach.

MURMAN: [00:46:31] OK. Yeah. I'm just, you know-- with the-- with the including the-- I don't know what the term was-- the instructions with the baby when it goes home from the hospital--

JEFF STEC: [00:46:46] That education plan.

MURMAN: [00:46:47] Yeah, the education.

JEFF STEC: [00:46:48] OK.

MURMAN: [00:46:49] If that-- I-- I assume that would include telling the-- the new parents that shaking would-- would be a common cause of the syndrome.

JEFF STEC: [00:47:02] Yes. Part of that education is around helping a family anticipate that there will be episodes or periods of time when a child will cry uncontrollably and to have a plan in place prior to that in an effort to prevent a level of frustration to rise to a place where you will hurt or harm that baby, inadvertently in some instances, but very significantly when it does happen.

MURMAN: [00:47:25] That's great to include that, yeah.

HOWARD: [00:47:29] Other questions? Seeing none, thank you for your testimony today.

JEFF STEC: [00:47:36] OK. Thank you.

HOWARD: [00:47:36] Other proponents for LB60? Seeing none, we do have three letters to read into the record: Ivy Svoboda from the Nebraska Alliance of Child Advocacy Centers; Britt Thedinger from Nebraska Medical Association; and Andy Hale from the Nebraska Hospital Association. Is there anyone wishing to testify in opposition to LB60? Anyone in a neutral capacity? Seeing none, Senator Cavanaugh, you are welcome to close. She waives closing and this closes the hearing for LB60. All right, and we'll move on to LB119, Senator Arch, to "provide for confidentiality of records and immunity from liability for professional healthcare services-- service entities involved in peer review. Senator Arch, whenever you're ready.

ARCH: [00:48:27] Thank you. Good afternoon, Senator Howard, m embers of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h. I represent the 14th Legislative District in Sarpy County. I'm here this afternoon to introduce LB119. LB119 expands the definition of healthcare provider under the Health Care Quality Improvement Act to include a professional healthcare service entity. This entity is defined as an organization that is not licensed under the Health Care Facility Licensure Act but which provides professional healthcare services through individuals credentialed under the Uniform Credentialing Act. Basically these are physician-run clinics. In other words, LB119 would provide employees of such clinics the same immunity protections offered to hospital personnel when it comes to peer review committees. This Legislature did not-- did an overhaul of our peer review statutes in 2011 and private clinics were not included at the time, yet these entities do conduct peer reviews. In order to ensure a peer review is thorough and comprehensive, thus improving outcomes, it is essential participants are able to communicate openly and honestly without fear of being subject to a suit or being held liable for actions taken within the scope of a peer review. Additionally, under LB119 any proceedings,

records, and reports of a peer review committee are deemed confidential and not subject to discovery or evidence in civil suit. Nothing in the current statute or in this bill prevents discovery or use in any civil action of records or information from original sources. It is my understanding the trial attorneys had some initial concerns about the language in the 2011 legislation as introduced but compromise language was worked out and the bill passed easily. Again, LB119 doesn't change anything that isn't currently practiced with respect to peer review committees in a hospital setting. It merely extends those provisions of law to medical clinics. Committees would still have to be formed and all the formal processes followed. It is also my understanding the trial attorneys have concerns with the bill and I'm more than willing to work with them on clarifying language if that is necessary. The purpose of peer reviews is to improve outcomes and guarantee patient safety. Patients at a clinic should be afforded the same benefits of a comprehensive peer review as patients in a hospital. This bill was brought to me by the Nebraska Medical Association. I know there will be testifiers who will be able to offer additional insight on the need for this legislation. However, I will try to answer any questions, and thank you, and I encourage you to advance LB119. I might add just a commentary on this. I of course have personally sat in on peer review committees as hospital administrator. They are critical. The physicians have to be able to speak freely to each other and-- and if-- if exposed to liability, they would tend not to speak freely and-- and to speak freely about their peers and it's-- it's sensitive information but they need to speak. And so this would provide this for physician-run clinics, for medical clinics. So happy to answer any questions if you have or we have testifiers to come with more technical knowledge.

B. HANSEN: [00:51:48] Yes.

HOWARD: [00:51:50] Senator Hansen.

ARCH: [00:51:50] Yeah.

B. HANSEN: [00:51:51] Yeah. So this is just in kind of layman's terms. You know, we've got peer review groups, so a group of your peers get together to discuss maybe an incident or something maybe, or discussing [INAUDIBLE] physician, almost like going into Executive Session?

ARCH: [00:52:00] Correct.

B. HANSEN: [00:52:01] So there is some kind, you know, protection from the law, I guess, and the litigation that might happen if you say something--

ARCH: [00:52:06] Right.

B. HANSEN: [00:52:06] -- about another peer that they may hear about later on. And this would especially go towards like primary care clinics, you know, or [INAUDIBLE]

ARCH: [00:52:14] Primary care specialty.

B. HANSEN: [00:52:15] -- that weren't included before maybe?

ARCH: [00:52:16] Yeah, right.

B. HANSEN: [00:52:18] OK [INAUDIBLE]

ARCH: [00:52:18] Exactly.

B. HANSEN: [00:52:20] OK.

ARCH: [00:52:20] Exactly.

HOWARD: [00:52:24] Other questions? Seeing none, you'll be staying to close?

ARCH: [00:52:26] I'll be staying.

HOWARD: [00:52:28] Thank you. Thank you, Senator. We'll open the testimony up for any proponent, anybody who's wishing to testify as a proponent for LB119. Good afternoon.

DANIEL ROSENQUIST: [00:52:52] Good afternoon. My name is Daniel Rosenquist, D-a-n-i-e-l, Rosenquist, R-o-s-e-n-q-u-i-s-t, address-- do you need the address or--

HOWARD: [00:53:02] Nope, not anymore.

DANIEL ROSENQUIST: [00:53:02] OK. Thank you. Thank you, Senator Howard and members of the committee, for allowing us to-- to bring this. And I'd also like to thank Senator Arch for introducing this bill. I'm a practicing family physician at Columbus Family Practice. I also have the privilege in Columbus, as many physicians do, to serve as part of the medical staff quality council at Columbus Community Hospital. And I'm also a board member of the Nebraska Coalition for Patient Safety and I presently-- currently I'm serving as the vice president. I'm here to speak in support of LB119. I would like to share and echo the thoughts and comments of Dr.-- or Mr. Arch, Senator Arch, about peer review. It's an undertaking of a professional and candid evaluation of a colleague's performance. It is an onerous responsibility, one that is greatly respected for its impact in quality improvement and patient safety. We practice medicine and continue to keep ourselves educated so that we can provide the best care to our patients, and we participate in peer review to

learn and ensure that all patients receive the best outcomes possible. Many times people are-- those people that are involved in peer review feel they learn more than actually-- from the peer review process, even when it's not their own care. I've seen firsthand the impact that peer review can have on learning and quality improvement both from the hospital peer-- peer review process and also from the work of the Coalition for Patient Safety where I also serve as the-- as chair of the reporting committee. From these experiences I can attest to the value of in-depth discussion around events and the factors and the circumstances in which they occur. These robust and impassioned discussions become the impetus for change and improvement. When an adverse outcome occurs, it affects not only us as providers but it also affects our whole healthcare delivery team. Embracing this realization has resulted in a shift of how peer review is perceived. Once thought of as a punitive process, it's now felt to be a quality and performance improvement process. This shift has-- has-- is not only-- has also triggered reviews not only of adverse events but also of near misses in which we-- we recognize that we have faults in the system and we can create change to try and help to prevent things in the future. These multidisciplinary, we talk-- they can occur in primary care clinics but also especially clinics, multispecialty clinics. And it's the whole team that gets involved in peer review to make a difference. Regularly I participate in this, in the peer review process, yet I realize I'm not afforded the same protections if I were to engage in this process with my group of seven physicians and four additional practitioners. While our family practice may not deal with the same degree of difficulty and severity in our day-to-day office visits, the sheer number of visits in an outpatient clinic leave the patient still at risk of potential adverse outcomes. It's unfathomable to think that we may be putting-- creating jeopardy for discussing adverse events or near misses in the name of improved safety and outcomes. This bill before you aims to bridge this gap by expanding privileges provided within the Nebraska Health Care Quality Improvement Act to other healthcare settings. Currently the-- the act provides protection or qualified immunity for the individuals who participate in peer review activities, but it also provides protection for the records of these peer review committees which conduct credentialing or other quality review activities involving the

assessment of competence, professional conduct, or quality of care by a healthcare provider entity. The current act's protections enable physicians and medical and facility staff to share information without fear of retribution from colleagues who are under review. Without these protections, important information would likely not be provided and patients could be at risk of-- increased risk of incompetent or inappropriate care. The current act extends protection only to peer review committees defined as a committee established by a governing board of a facility which is a healthcare provider, meaning a state licensed hospital and ambulatory surgery-- surgery center or a health clinic. It does not apply to the medical residencies the offices, or the clinic of a practitioner or a group of practitioners like my own. This is not unprecedented. While peer review may be typically thought of as a-- as being performed by a healthcare facility, under the federal Health Care Quality Improvement Act, a healthcare entity includes a group medical practice that follows a formal peer review process for the purpose of furthering quality healthcare. Physician practices should be incentivized to perform these same reviews in Nebraska for the benefits of its system, its citizens. Senator Howard and members of the Health and Human Services Committee, communication, evaluation, learning and improvement are essential to delivering the best healthcare to our patients and it is the responsibility of all healthcare providers across all health settings. I encourage you to consider supporting LB119. Thank you.

HOWARD: [00:57:49] Thank you, Doctor. Are there questions? Senator Williams.

WILLIAMS: [00:57:53] Thank you, Madam Chairman. Thank you, Doctor, for being here today and helping us understand this process. I think I understand how the process currently works. Could you tell me from-- from a logistical and mechanical standpoint with your private practice, how would you-- how would you endeavor to do this in your practice?

DANIEL ROSENQUIST: [00:58:13] We will set up a committee of selected physicians and then

probably some other interested parties, like our-- our lead nurse, some of our other quality people that we do within our practice, to try and sit down and evaluate these events, gather the information, look at it from a multidisciplinary approach, and to see what-- try to research what are the best practices out there and how can we implement those in our offices to make a difference.

WILLIAMS: [00:58:41] Does the committee then, I'll use that term, that-- that you would put together, do they segregate records that would be available that would be used by the committee?

DANIEL ROSENQUIST: [00:58:52] Yes. That would-- that would be our intention.

WILLIAMS: [00:58:55] OK. My question then goes to your-- your practice has, give or take, 10-11 docs in it. If you come to Gothenburg, we don't have that many docs. In a small clinic, let's-- let's assume a clinic with a doc, a PA, and then some office staff, how-- how would you walk through, do you believe, setting up this system there--

DANIEL ROSENQUIST: [00:59:22] In a one or even a--

WILLIAMS: [00:59:22] -- or your suggestion of having it?

DANIEL ROSENQUIST: [00:59:24] Even in a one- or two-physician or provider practice, I think that you would-- I think part of it would be the formalization of a committee and involvement of a certain-- a couple of individuals, nurses, in that part of things, teachers or whoever is the interested parties, to look at and evaluate things and to try and, again, determine what the best practices are and how that-- can implement it in your individual practice because it may be different from practice to practice.

WILLIAMS: [00:59:51] Could you envision a case in a small clinic where the entire staff would be the peer review committee?

DANIEL ROSENQUIST: [00:59:58] I could. I don't know if that's feasible or not just because of the volume-- because of the logistics of everything that would be involved, but possibly.

WILLIAMS: [01:00:07] My concern in going down this path that I would address or would ask you about is, is there an opportunity in a situation, especially in a smaller situation like that, knowing that the-- the peer review committee then is in charge of segregating records that could or could-- could or would be used, could the establishment of a peer review committee end up being a shield to legal action?

DANIEL ROSENQUIST: [01:00:36] That's always the concern. And I recognize that's the concern of people who are not-- not in favor of this. But I think at the same time it's our one opportunity to look and analyze our own care and ourselves to try and-- again, that multidisciplinary approach to get different-- different slants on the-- the events and the outcomes and what could be do-- what could be done to manage that.

WILLIAMS: [01:01:02] Thank you.

HOWARD: [01:01:02] Other questions? I want to be clear in my own mind about how right now in your family practice you're not able to discuss with your peers an adverse event if there's-- if somebody has filed a lawsuit or not at all?

DANIEL ROSENQUIST: [01:01:20] In a protected environment, not at all.

HOWARD: [01:01:23] In a protected environment.

DANIEL ROSENQUIST: [01:01:25] Not in a protected environment.

HOWARD: [01:01:26] OK. Do you still discuss adverse events anyway?

DANIEL ROSENQUIST: [01:01:29] We have to.

HOWARD: [01:01:31] Yeah.

DANIEL ROSENQUIST: [01:01:32] I mean but at the same time that's a discussion between-- and I-- and I happen to serve as the de facto risk manager for our office so I become the person who discusses these outcomes. But unfortunately, and I see this with the Coalition for Patient Safety and my other work, that one person will change their practice but that doesn't prevent the other nine people in our practices from changing their practices and their habits. And that doesn't allow us to give some of that information out to the nursing and to the other ancillary personnel. So do we do peer review? Yes. But does it encompass all the things that we could potentially do? It doesn't-- it doesn't solve all of our problems. And unfortunately we will find these events get repeated over and over and over because we can't change. We need to change the system.

HOWARD: [01:02:23] OK. Thank you, Doctor. Thank you for your testimony today.

DANIEL ROSENQUIST: [01:02:26] Thank you.

HOWARD: [01:02:28] All right, our next proponent for LB19-- LB119. Good afternoon.

DAVID BUNTAIN: [01:02:37] Senator Howard, greetings. My name is David, B-u-n-t-a-i-n. I am an attorney with the Cline Williams law firm and am legal counsel to Nebraska Medical Association. In a previous life I was a lobbyist for the Nebraska Medical Association for 29 years. And I don't recognize this committee from the last time I testified, which was probably five or six years ago. But congratulations to all of you. It's-- you're-- you're doing very important work here. Dr. Rosenquist did a great job of explaining peer review and I think the critical thing to understand is that this is a minor tweak to the current peer-- peer review law. We've had a peer review law since 1971. In 2011, we made a major change, changing the substance and kind of bringing it up to date with current law. At that time we continued the scope of the peer review law, which was it applied to peer review that was done in hospitals and in ambulatory surgical centers. At that time we didn't anticipate the situation which has developed since then which is as-- as physician office clinics have grown, there is-- and more kinds of things are being done in physician offices, there's more interest in doing peer review and there's a recognition that there are risks involved to-- to persons involved either in bringing forward concerns or in reviewing the concerns and in deliberating about them because they don't have the same protection that you have in a hospital or ambulatory surgical center. So this was brought to us by some physician groups that are interested in doing peer review. I will point out it's permissive for physician offices. I don't-- I expect a lot of physician offices won't choose to do this. But Senator Williams asked the question about a small office. I would-- I think it would be less likely with one or two physician offices that you'd have peer review. You wouldn't have kind-- kind of the same impetus for it that you would have with a-- with a larger group. And you need a more-- the larger practices are more structured and would allow for having the kind of committee that Dr. Rosenquist has talked about. The other thing that is important to know is that the peer review process as it currently exists provides that it does not shield from discovery any existing medical record. So anything that is generated in connection with patient care, the kinds of records we're all familiar with, the-- the histories and physicals, the lab work, doctor's notes on individual patients that they see, all of those records under the peer review

are discoverable. The-- the portion of the records that are protected are the records of any deliberations of the peer review committee. And so those records would-- the typical records that would be sought, say, in a malpractice claim or if-- if someone had a complaint against a physician that went to the Department of Health Human Services, all of those underlying principle records are still available and you can't use the peer review law to-- to hide those. So I think those are the main things I wanted to cover. If there's any questions about this-- we do appreciate Senator Arch bringing this forward, and we will be happy to visit with the trial attorneys. I did have a brief conversation with John Lindsay and I think I understand what their concern is. I think we can-- can work something out to address what-- what you hear from them about, so.

HOWARD: [01:06:55] Thank you.

DAVID BUNTAIN: [01:06:57] Yes, thank you.

HOWARD: [01:06:58] Are there questions? Senator Williams.

WILLIAMS: [01:06:59] Thank you, Chairwoman Howard. And thank you, Dave, for being here. And thank you for clearing up that records thing for me. I appreciate that. My question would be, where-- where do-- we are seeing more and more family practice clinics, at least in rural areas, actually be owned by the hospital and operated that way.

DAVID BUNTAIN: [01:07:22] Yes.

WILLIAMS: [01:07:22] How does peer review or how can peer review work in that situation?

DAVID BUNTAIN: [01:07:28] Well, it clearly can be done. It's a question of-- it would be up to

the--

WILLIAMS: [01:07:33] I guess my question is, can it currently be done if the-- if the hospital owns the clinic, hires the doctors, you know, pays them, that's the system that we're seeing a lot more of. Can they do peer review now or would they-- would this law just clarify that they can do it [INAUDIBLE]

DAVID BUNTAIN: [01:07:51] I think this would clarify it. I think the way the law would be interpreted now is that it's-- it's care that's provided in a licensed facility, which would be a hospital or-- or ambulatory surgical center. Other kinds of practitioner offices, physicians and otherwise, are not licensed by the state.

WILLIAMS: [01:08:10] Thank you.

HOWARD: [01:08:13] Other questions? Senator Hansen.

B. HANSEN: [01:08:14] So maybe I need to read, look into this a little bit further about what constitutes a healthcare facility. Is this strictly for medical doctors or this include DOs, DCs?

DAVID BUNTAIN: [01:08:28] The-- the way that the law currently is written, it's licensed hospitals and ambulatory surgical centers. What we are proposing would allow peer review by any organization, office of healthcare practitioners, not just physicians, so it would include optometrists, chiropractors, podiatrists--

B. HANSEN: [01:08:48] Cool. That's what I was wondering. OK.

DAVID BUNTAIN: [01:08:50] -- physical therapists.

B. HANSEN: [01:08:50] I'm a chiropractor. I own my own clinics and I'm just wondering [INAUDIBLE] clarifies with me. Great. I can do a peer review.

DAVID BUNTAIN: [01:08:54] I live in Blair so I-- you-- Senator, you were on my ballot, so.

HOWARD: [01:09:01] Other questions? Seeing none, thank you for your testimony today.

DAVID BUNTAIN: [01:09:06] All right. Thank you.

HOWARD: [01:09:06] Anyone else wishing to testify as a proponent for LB119? Seeing none, anyone wishing to testify in opposition to LB119? Seeing none, anyone wishing to testify in a neutral capacity? Good afternoon.

JASON AUSMAN: [01:09:31] Good afternoon, Senators. Chairperson Howard, members of the committee, my name is Jason Ausman, J-a-s-o-n, last name is A-u-s-m-a-n. I'm here this afternoon on behalf of the Nebraska Association of Trial Attorneys. Our interest here today is to balance the goal of better patient care for everybody with the interests of a patient to efficiently learn the truth in the face of an adverse medical event. At first glance-- I'm familiar with peer review with my own practice. At first glance I was frankly surprised that these physician groups were not included in the original legislation for peer review. And the first question that came to my mind is, why were private practices, such as that practice run by Dr. Rosenquist, not included in the original legislation? Some of the concerns that we have with the bill go to what you had addressed earlier, Senator Williams. With the hospital groups, with the ambulatory surgical groups, the appearance of structure and formality exists. Right, wrong, or in between, that-- that appearance exists. With the

private groups, especially when we start getting into the smaller groups, the questions become-- well, the lines become blurred a little bit. What is peer review protected and what is not? It's not just records that are created in these peer review committees. It's also communication that is sought to be protected. If there is communication in a hallway between two practitioners, whether it's doctor/nurse, two nurses, PAs, etcetera, is that communication, done informally or casually, is that now subject to peer review protection? It's not peer review that we're seeking to get rid of. It's just we're looking for a little bit more structure in terms of how this is going to work in practice.

HOWARD: [01:12:12] Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: [01:12:16] Thank you. Thank you for your testimony today. So the communication is protected and-- but the medical records of the patient, if the patient is seeking litigation, would not be protected. The patient could use those records, correct?

JASON AUSMAN: [01:12:35] So there are two different types of records. As-- as the gentleman before me testified, the patients-- the physicians, the medical care providers will generate a record when a patient appears for treatment, for care, history and physical, labs, diagnostic testing. All of those records, those documents become part of the patient chart and that is discoverable to anyone regardless of whether or not there's been a peer review committee conducted as it pertains to that patient's care. When a peer review committee takes place, when they convene and meet about a particular patient, I haven't been part of that, but it's my understanding that written documents, records, if you will, will be prepared in connection with that review. Those documents, those records are protected. They are not discoverable by anyone outside of that committee's review. OK? So I think that that's the issue with records. The patient's records are always discoverable. Any records or documents that are created in connection with the peer review committee itself, those are not subject to discovery.

CAVANAUGH: [01:14:02] OK.

JASON AUSMAN: [01:14:02] It is-- and I hope I'm answering your question, Senator. It's my understanding that as part of peer review committee protection, it's not just written documents that are protected but it's the communication, the conversation between the providers that is also protected. And some of the concerns that we have going to a facility, a doctor's clinic, an office such as that, that is seeking protection under this law is, where do those lines blur? Is it casual conversation that's subject to discovery? Are those communications subject to discovery in the event that a suit is filed? Or are those conversations protected under the guise of peer review?

CAVANAUGH: [01:14:54] So I-- additional question. So the conversation, it would appear conversation is protected, privileged information between the parties involved. But is it your understanding--I'm just looking for clarification--that the individuals participating in these privileged conversations, are they also protected or can they be brought in to discuss not the conversations that they've had but their own point of view, their own experience, their own information with the case?

JASON AUSMAN: [01:15:28] I think I understand your question, Senator. These folks, if a lawsuit were to generate from an adverse medical event, even though a peer review committee has been formed and the patient's care and treatment has been discussed, these medical care providers are still subject to questioning via deposition, at trial. We can certainly ask questions about that patient's care. It's just the communication--

CAVANAUGH: [01:15:59] Between--

JASON AUSMAN: [01:15:59] -- that is sought to be protected under the guise of peer review, that cannot be discovered. And so our interest here today is to-- we want to make sure that the goal with these privilege assertions is better patient care as opposed to protection in the event of a lawsuit.

CAVANAUGH: [01:16:26] And to Senator Williams' question earlier, if there's only two people in a clinic and they both can be questioned, then I guess my-- my concern over them not being-- or using it as a way to hide something would be kind of resolved because you can easily question two individuals.

JASON AUSMAN: [01:16:46] The opportunity would-- is greater--

CAVANAUGH: [01:16:48] Yes.

JASON AUSMAN: [01:16:50] -- in theory.

CAVANAUGH: [01:16:50] OK. Thank you.

JASON AUSMAN: [01:16:52] You bet.

HOWARD: [01:16:53] Other questions? Senator Williams.

WILLIAMS: [01:16:55] Thank you, Chairman. And thank you for being here. You raised the issue here, the balancing act here. Do you have suggestions to put that together? Mr. Buntain talked about the willingness to talk about any concerns that you might have. Do you have suggestions on those lines?

JASON AUSMAN: [01:17:16] I don't have anything specific other than to tell you that I know that there are best practices that are used as guides by hospitals, clinics in these situations. And maybe with a little more homework, we can come up with some language, some better structure that we can all be satisfied with.

WILLIAMS: [01:17:37] You can go back to your law firm and find a peer reviewed group there to talk about, right?

JASON AUSMAN: [01:17:41] Yeah, exactly. All right. Thank you, Senator.

HOWARD: [01:17:44] Other questions? I just have-- help me understand our trial attorneys in Nebraska having a hard time with discovery because of peer review for the organizations that are already covered by this immunity.

JASON AUSMAN: [01:18:04] Here's how this works in a practical world. We send written questions called interrogatories and we send requests for production of documents. And we ask the medical care provider through their attorney to produce information. And we will from time to time, depending upon how the question is asked or depending upon if peer review committees have been conducted or peer reviews have been performed, we will get an objection and it will say that is subject to peer review. Many times when I see something like that, I think to myself, well, we're-- that's kind of the end of the road here, and-- and-- and we leave that alone. There are additional protections afforded. Frankly if somebody in my shoes were to push the envelope and-- and ask, inquire into that with a judge, we'd file a motion to compel. And the medical care provider asserting the privilege, it is my position that they would be required to file some type of a privilege log and show the judge what documents are not being disclosed under the assertion of it being privileged. OK? So practically speaking, I receive these objections and I have not followed up with a motion to

compel and actually gone that distance. It's kind of a, all right, that's going to be claimed as-- as privileged information and we're not going to get anywhere with that. So I don't know how to-- how to really answer your question. It's-- it's trying to look behind a door that we can't see behind.

HOWARD: [01:20:10] So-- so your neutral testimony, which sounds a little like opposition but you're willing to work on it, is-- is in the structure of how it works in practice. And my understanding is that it's already working in practice, they're just asking for additional entities to be covered. And so my question was, is it not working? Are you not getting what you need in order to file cases or get enough of what you need from interrogatories? Are you asking for an additional structure to be put in place so that you can prove that a peer review committee was actually formed to look at this adverse circumstance?

JASON AUSMAN: [01:20:47] I don't think so. I don't think that's our goal. And the reason why we're neutral and not in opposition to this bill is because when you hear the folks talking about the benefits of peer review, it's our hope that that is leading to better patient care, better patient outcomes for everybody. We'd never want to stand in the way of that. All right? It's just that when you go from a formal setting, like a hospital or a surgical center, and you extrapolate that to a smaller setting where there may be only one or two or three providers, theoretically, if those providers all form a committee, any conversation that they have could then theoretically be considered protected. And if you look at the statute, I think that what the statute says is they're-- they're not required to tell anybody what that communication consisted of, but they're also not permitted to tell anybody what the substance of that communication was. And so our fears are we start to get away from the formal settings of a hospital, have surgical centers, into a smaller clinic, what's protected and what's not? And those lines get blurred.

HOWARD: [01:22:16] Thank you.

JASON AUSMAN: [01:22:17] All right.

HOWARD: [01:22:18] Any other questions? Seeing none, thank you for your testimony today.

JASON AUSMAN: [01:22:20] Thank you.

HOWARD: [01:22:21] Is there anyone else wishing to testify in a neutral capacity on LB119? Seeing none, Senator Arch, you are welcome to close. He waives closing. This concludes the hearing for LB119 and all of our hearings for the day. So congratulations-- we're done early.